INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Healthy Indiana Plan

LIBRARY REFERENCE NUMBER: PROMOD00054
PUBLISHED: JUNE 5, 2018
POLICIES AND PROCEDURES BEGINNING FEBRUARY 1, 2015
VERSION: 1.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures beginning February 1, 2015 Published: June 5, 2018	New document	FSSA and DXC

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Waiver/Authority

The Healthy Indiana Plan (HIP) 2.0 operates under a 1115(a) Medicaid demonstration waiver that provides authority for the State to provide healthcare coverage for adults between the ages of 19 and 64 through a managed care health plan and a consumer-directed model that provides accounts, similar to a health savings account, called a Personal Wellness and Responsibility (POWER) Account. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of requirements under section 1902(a) of the *Social Security Act*. The demonstration is operating statewide and was approved for a 3-year period, from February 1, 2015, through January 31, 2018.

Under HIP 2.0, Indiana is building on and changing its previous HIP program 1.0 in multiple ways, including the creation of new benefit plans and the establishment of a broader incentive structure to encourage healthy behaviors. Other changes are effective through this demonstration, which provides authority for the charging of POWER Account contributions, the implementation of healthy behavior incentives, and a premium assistance program for individuals with employer-sponsored insurance (ESI). Some of those changes, including the creation of *Basic*, *Plus* and *HIP Link* benefit plans are being implemented through the State Plan.

With this demonstration waiver, Indiana expects to achieve the following to promote the objectives of Title XIX:

- Promoting increased access to healthcare services
- Encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness
- Increasing quality of care and efficiency of the healthcare delivery system
- Promoting private market coverage and family coverage options through *HIP Link* to reduce network and provider fragmentation within families

Over the 3-year period, Indiana seeks to demonstrate the following:

- Whether a monthly payment obligation linked to a POWER Account will result in more efficient use of healthcare services
- Whether the incentives established in this demonstration for beneficiaries to obtain preventive services and engage in healthy behaviors will result in better health outcomes and lower overall healthcare costs
- Whether POWER Account contributions in lieu of cost sharing for individuals participating in the *HIP Plus* plan will affect enrollment, utilization, and the use of preventive and other services by beneficiaries

HIP 2.0 Program Overview

HIP 2.0 is a program sponsored by the state of Indiana that provides an affordable healthcare choice to thousands of individuals throughout Indiana. Eligibility is limited to adults who meet all the following criteria:

- Between the ages of 19 and 64
- With income at or under 138% of the federal poverty level (FPL) (133% plus 5% disregard = 138%)
- Not on Medicare
- Do not qualify for any other Medicaid program

HIP is a managed care program with pharmacy and dental services, when applicable, carved into the managed care arrangement. Indiana offers HIP members a comprehensive benefit plan through a deductible health plan paired with a personal healthcare account called a POWER Account.

Under HIP 2.0, beneficiaries are served with specific benefit plans based on their eligibility category. The benefit plans are as follows:

- *HIP Plus*
- *HIP Basic*
- *HIP State Plan – Plus*
- *HIP State Plan – Basic*
- *HIP Maternity*
- *HIP Plus Copay*

See the *HIP 2.0 Eligibility and Benefit Plans* section for specific coverage and eligibility information related to each benefit plan.

The HIP 2.0 program does not offer retroactive eligibility to members. HIP members are not fully eligible, nor enrolled as members, until one of the following occurs:

- Payment of their first POWER Account contribution
- A $10 Fast Track payment to the selected health plan (if applicable)
- For individuals at or below 100% FPL, the expiration of the 60-day payment period

HIP-accepted members who are still in the initial 60-day payment period and who have not yet paid their first POWER Account contribution are referred to as *conditionally eligible*. Members who are conditionally eligible do not have any benefits until they move into a fully eligible category.

Fast Track Enrollment

Fast Track is a payment option that allows eligible Hoosiers to expedite the start of their coverage in the *HIP Plus* program. Fast Track allows a $10 prepayment to be made while the application is being processed. The $10 prepayment goes toward the applicant's first POWER Account contribution. For applicants that make a Fast Track prepayment and are eligible for HIP, their *HIP Plus* coverage will begin the first of the month in which they made their Fast Track prepayment.

If an individual does not make a credit card payment at the time of application, he or she will be invoiced by the managed care entity (MCE) to which the individual is assigned. From the date the invoice was issued, the individual has 60 days to make either a Fast Track prepayment or his or her first POWER Account contribution to be able to begin *HIP Plus* coverage. If the individual makes his or her Fast Track payment or first POWER Account contribution in July, then his or her *HIP Plus* coverage will begin July 1. If the individual makes the contribution in August, *HIP Plus* coverage will begin August 1. If the individual allows the 60-day payment period to expire in August without making either a Fast Track prepayment or POWER Account contribution, then one of the following occurs:

- If the individual's income is at or below 100% of the FPL, the coverage defaults to *HIP Basic* effective August 1.
- If the individual's income is over 100% of the FPL, he or she would not receive coverage and would have to reapply for HIP enrollment.

HIP 2.0 Eligibility and Benefit Plans

HIP 2.0 members receive coverage under one of the benefit plans:

- ***HIP Plus*** (MA RP) – This plan is available for all members enrolled in HIP who choose to make affordable monthly contributions to their individual POWER Account. Members enrolled in *HIP Plus* receive a more generous benefit package, including vision and dental services.
- ***HIP Basic*** (MA RB) – This plan is for members with income at or below 100% FPL who fail to make a POWER Account contribution. *HIP Basic* requires the member to make copayments at the point of service for each service received from a provider. Copayments for services received are $4 or $8 for most services and prescriptions. There is a $75 copayment for inpatient hospitalization. *HIP Basic* has a more limited benefit package and does not cover vision or dental services. *HIP Basic* has a more limited formulary for pharmacy.
- ***HIP State Plan – Plus*** (MA SP) – This plan offers access to all benefits available under the State Plan. Members with this benefit plan have the same cost-sharing requirements as *HIP Plus*, must make monthly POWER Account contributions, and do not have copayments for services.
- ***HIP State Plan – Basic*** (MA SB) – This plan offers access to all benefits available under the State Plan. Members with this benefit plan have the same cost-sharing requirements and copayments for all services as *HIP Basic* members.
- ***HIP Maternity*** (MA GP) – This plan offers additional benefits to match other full-benefit maternity coverage with no cost sharing for the member. Members who are enrolled in HIP and become pregnant may opt to continue HIP enrollment or may move to the Hoosier Healthwise program. A woman who is pregnant during her redetermination must move to Hoosier Healthwise for the remainder of her pregnancy and post-partum coverage.
- ***HIP Plus Copay*** (MA PC) – This plan offers the coverage of *HIP Plus* benefits but requires copayment for all services. Copayments match those for *HIP Basic* at $4, $8, or $75. This is a limited-enrollment category that is reserved for members who are above 100% FPL but are medically frail and therefore do not lose benefits for failure to pay POWER Account contributions.
- ***Presumptive Eligibility – Adult*** (MA HA) – Members who go through the Presumptive Eligibility (PE) process and are found eligible based on HIP eligibility criteria are assigned to the *PE Adult* benefit plan. The coverage in this plan mirrors the benefit and cost-sharing required in *HIP Basic*.

Table 1 provides an overview of the benefits available under the HIP plans. For more detailed information about the specific services covered under *HIP Plus* and *HIP Basic*, see Tables 2–63.

Table 1 – Benefit Coverage Summary for HIP Benefit Plans

Benefit Category	HIP State Plan	HIP Basic	HIP Plus	HIP Maternity*
Ambulatory Patient Services	X	X	X	X
Emergency Services	X	X	X	X
Urgent Care	X	X	X	X
Hospitalization	X	X	X	X
Maternity and Newborn Care**	X	X	X	X
Mental Health and Substance Use Disorder Services (Including Behavioral Health Treatment)	X	X	X	X
Rehabilitative and Habilitative Services and Devices	X	X	X	X

Benefit Category	HIP State Plan	HIP Basic	HIP Plus	HIP Maternity*
Laboratory Services	X	X	X	X
Preventative and Wellness Services	X	X	X	X
Chronic Disease Management	X	X	X	X
Prescription Drugs	X	X	X	X
Medicaid Rehabilitation Option	X			X
Adult Vision	X		X	X
Adult Dental	X		X	X
Chiropractic Services	X			X
Nonemergency Transportation	X			X

** HIP Maternity benefits are available to all HIP members who become pregnant, regardless of their benefit plan assignment.*

*** Newborns born to HIP members will be covered through Medicaid for children.*

HIP Basic and HIP Plus Benefit Plans

HIP benefits for *HIP Plus* and *HIP Basic* are based on approved alternative benefit plans. *HIP Plus* and *HIP Basic* are distinct benefit plans with different coverage, limitations, and prior authorization (PA) requirements. Members who are in *HIP Plus* or *HIP Basic* and become pregnant are eligible for enhanced services, even before being moved to the *HIP Maternity* benefit plan. For specific billing and coding information, refer to the member's assigned MCE for directions.

Table 2 – Primary Care Physician (PCP) Services – Office Visits

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Office visit services include supplies for treatment of the illness or injury, medical consultations, procedures performed in the physician's office, second opinion consultations, and specialist treatment services provided by the member's PCP. **Duration/Scope Limit**: None	For second opinion consultations, the MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 3 – Specialty Physician Visits

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Referral physician office visit included. **Duration/Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 4 – Home Health Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Home health services are covered only if not considered custodial care and prescribed in writing by a participating physician as medically necessary in place of inpatient hospital care or convalescent nursing home and services provided under physician's care. Services include skilled medical services; nursing care given or supervised by a registered nurse (RN); nutritional counseling furnished or supervised by a registered dietician (RD); home hospice services; home health aides; laboratory services, drugs, and medicines prescribed by a physician in connection with home health care; and medical social services. **Duration/Scope Limit**: 100 visits per year	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Within the benefit, training of family members to provide home health services is noncovered. Home hospice services are considered a separate service.

Table 5 – Outpatient Surgery

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Outpatient medical and surgical hospital services are covered when medically necessary. Includes diagnostic invasive procedures that may or may not require anesthesia. **Duration/Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 6 – Allergy Testing

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Includes allergy procedures-administration of serum. **Duration/Scope Limit**: None	None

Table 7 – Intravenous (IV) Infusion Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Includes coverage for outpatient infusion therapy. **Duration/Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 8 – Chemotherapy – Inpatient and Outpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Includes outpatient therapeutic injections that are medically necessary and may not be self-administered. Includes coverage for inpatient chemotherapy services. **Duration/Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 9 – Radiation Therapy – Inpatient and Outpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Includes coverage for inpatient and outpatient services. **Duration/Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 10 – Dialysis – Inpatient and Outpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Coverage provided for outpatient (including home) dialysis services provided by a participating provider. Coverage provided for inpatient dialysis services provided by a participating provider. **Duration/Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 11 – Nonsurgical Treatment Option for Morbid Obesity

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Covered service for enrollment in a physician-supervised weight-loss treatment program when referred by the member's physician. **Duration/Scope Limit**: Six visits per calendar year for program	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 12 – Outpatient Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Includes colonoscopy and pacemaker. Benefits provided are PCP, specialty, and referral for all physician services in an outpatient facility. **Duration/Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 13 – Clinical Trials for Cancer Treatment

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Coverage provided for routine care costs that are incurred in the course of a clinical trial. The clinical trial must be approved or funded by one of the following: • National Institute of Health (NIH) institute • Cooperative group of research facilities that has an established peer review program that is approved by an NIH institute or center • Food and Drug Administration (FDA); • U.S. Department of Veterans Affairs • U.S. Department of Defense • Institutional review board of an institution located in Indiana that has a multiple-project-assurance contract approved by the NIH Office for Human Research Protection • Research entity that meets eligibility criteria for a support grant from an NIH center **Duration/Scope Limit**: None	MCEs may establish PA requirements such as: • General member information • Review of clinical trial to ensure qualified • Review of routine costs related to clinical trial • A justification of services rendered for the medical needs of the member Items and services that are not routine care costs or that are unrelated to the care method will not be covered.

Table 14 – Dental – Accident or Injury Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Injury to sound and natural teeth including teeth that have been filled, capped, or crowned. **Duration/Scope Limit**: Treatment complete within 1 year from initiation	MCEs may establish PA requirements such as: • General member information • Reporting injury to insurer and receiving follow-up care within specified time frame • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Coverage not provided for orthodontia, dental procedures, repair of injury caused by an intrinsic force (such as the force of the upper and lower jaw in chewing), or repair of artificial teeth, dentures, or bridges.

Table 15 – Urgent Care/Walk-Ins

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Coverage includes after-hours care. **Duration/Scope Limit**: None	None

Table 16 – Routine Foot Care

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases. **Duration/Scope Limit**: Six visits per year	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Coverage not provided for supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions, and calluses.

Table 17 – Voluntary Male Sterilization

HIP Plus and HIP Basic	Prior Authorization and Exclusions
This benefit is provided via substitution from the State Plan and replaces infertility diagnoses and treatment. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • A planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 18 – Emergency Department Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Emergency room included. **Duration/Scope Limit**: Emergency services outside the United States are not covered.	

Table 19 –Emergency Services Outside the United States

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Medical care provided outside the United States is not covered. **Duration/Scope Limit**: Not covered	Not applicable

Table 20 – Ambulance – Independent and Provider Based – Air and Ground

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Other medically necessary ambulance transport (ambulance, medi-van, or similar medical ground, air or water transport to or from the hospital or both ways, and transfer from a hospital to a lower level of care) is covered when ordered by the PCP. **Duration/Scope Limit**: None	For other medically necessary transportation, authorization may be required in which the MCEs may require: • Other details, such as general member information • Contacting the PCP for other types of transportation-related services • A justification of services rendered for the medical needs of the member

Table 21 – General Hospital Care – Inpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Services include: • Semiprivate room and board (private room provided when medically necessary) • Intensive care unit/coronary care unit • Inpatient cardiac rehabilitation limited to an annual maximum of 90 days and inpatient rehabilitation therapy limited to an annual maximum of 90 days • General nursing care • Use of operating room or delivery suite • Surgical and anesthesia services and supplies • Ordinary casts • Splints and dressings • Drugs and oxygen used in hospital • Laboratory and x-ray examinations • Electrocardiograms • Special duty nursing (when requested by a physician and certified as medically necessary) • Inpatient specialty pharmaceuticals **Duration/Scope Limit**: See above	MCEs may establish PA requirements, such as: • General member information • Review of medical necessity, authorization by acting physician • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Benefit does **not** include: personal comfort items (including those services and supplies not directly related to care, such as guest meals and accommodations or personal hygiene products) or and room and board when temporary leave permitted.

Table 22 – Inpatient Physician Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit includes PCP and specialty. Referral for physician services in the hospital may be required. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 23 – Inpatient Surgical Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Surgical hospital services are covered when medically necessary. Services include • Semiprivate room and board (private room provided when medically necessary) • Intensive care unit/coronary care unit; inpatient cardiac rehabilitation and inpatient rehabilitation therapy limited to an annual maximum of 90 days • General nursing care • Use of operating room or delivery suite • Surgical and anesthesia services and supplies • Ordinary casts • Splints and dressings • Drugs and oxygen used in hospital • Laboratory and x-ray examinations • Electrocardiograms • Special duty nursing (when requested by a physician and certified as medically necessary) • Inpatient specialty pharmaceuticals Surgical operations may include replacement of diseased tissue removed while a member. **Duration/Scope Limit**: See above	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Benefit does **not** include: • Bariatric surgery (see *Table 63 – Bariatric Surgery* for *HIP Plus* benefit) • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) for *HIP Basic* (TMJ treatment is a covered service for *HIP Plus*) • Personal comfort items (including those services and supplies not directly related to care, such as guest meals and accommodations or personal hygiene products) • Room and board when temporary leave permitted

Table 24 – Noncosmetic Reconstructive Surgery

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Surgical hospital services are covered when medically necessary and approved by physician. Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident occurring while a member. **Duration/Scope Limit**: Services begin within 1 year of the accident.	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Benefit does **not** include personal comfort items (including those services and supplies not directly related to care, such as guest meals and accommodations or personal hygiene products) or room and board when temporary leave permitted.

Table 25 – Mastectomy – Reconstructive Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Surgical hospital services are covered when medically necessary and approved by physician. Covered services include reconstruction of the breast upon which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Benefit does **not** include personal comfort items (including those services and supplies not directly related to care, such as guest meals and accommodations or personal hygiene products) or room and board when temporary leave permitted.

Table 26 – Human Organ Transplant

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Includes human organ and tissue transplant services for both the recipient and the donor, when the recipient is a member. No coverage is provided for the donor or the recipient when the recipient is not a member. Specialty care physician (SCP) provides pretransplant evaluation. Nonexperimental, noninvestigational organ and other transplants are covered. The donor's medical expenses are covered if the person receiving the transplant is a member and the donor's expenses are not covered by another issuer. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Transportation and lodging services for the donor are considered a noncovered benefit.

Table 27 – Congenital Abnormalities

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Surgical hospital services are covered when medically necessary and approved by physician. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Benefit does **not** include personal comfort items (including those services and supplies not directly related to care, such as guest meals and accommodations or personal hygiene products) or room and board when temporary leave permitted.

Table 28 – Anesthesia

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Coverage includes anesthesia services and supplies. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 29 – Hospice

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Covered services include semiprivate room; private room provided when medically necessary. Hospice care provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is 6 months or less. Concurrent care is provided to children (19 and 20 years old). **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Room-and-board services are not covered when temporary leave permitted.

Table 30 – Medical Social Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Includes hospital services to assist member and family in understanding and coping with the emotional and social problems affecting health status. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 31 – Cardiac Rehabilitation – Inpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit includes services for the improvement of cardiac disease or dysfunction. **Duration/Scope Limit**: 90 days annual maximum	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 32 – Rehabilitation Therapy – Inpatient

HIP Plus and Basic	Prior Authorization and Exclusions
Coverage includes physical, occupational, speech, and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning. Rehabilitative and habilitative services are offered at parity and share the same or comparable benefit limits. **Duration/Scope Limit**: 90 days annual maximum	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 33 – Maternity Care

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Maternity coverage is provided from the State Plan and includes various obstetrical services, such as antepartum and postpartum visits, laboratory and x-ray (ultrasound) services, and other services as medically necessary and appropriate. The benefit provides for antepartum services up to 14 visits for normal pregnancies. High-risk pregnancies may allow for additional visits. Postpartum services include two visits within 60 days of delivery. **Duration/Scope Limit**: See above	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Newborn coverage is not included in HIP. Newborns born to members will be covered through Medicaid for children.

Table 34 – Maternity – Delivery

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Delivery coverage is provided from the State Plan and includes inpatient hospital care and services, physician services, laboratory and x-rays services, and other services as medically necessary and appropriate. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Newborn coverage is not included in HIP. Newborns born to members will be covered through Medicaid for children.

Table 35 – Mental/Behavioral Health – Inpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefits include evaluation and treatment in a psychiatric day facility, partial hospitalization, and electroconvulsive therapy. These services are not provided through institutions of mental disease (IMDs). **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Benefit does **not** include: • Hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders • Personal comfort items • Room and board when temporary leave available

Table 36 – Mental/Behavioral Health – Outpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Coverage applies to individual therapy and group therapy sessions. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Coverage does **not** include: • Self-help training or other related forms of nonmedical self-care • Marriage counseling • Hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders

Table 37 – Substance Abuse Treatment – Inpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit includes detoxification for alcohol or other drug addiction and partial hospitalization. These services are not provided through IMDs. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Benefit does **not** include: • Services and supplies for the treatment of codependency or caffeine addiction • Personal comfort items • Room and board when temporary leave permitted

Table 38 – Substance Abuse Treatment – Outpatient

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Coverage includes detoxification for alcohol or other drug addiction. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Benefit does **not** include services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction.

Table 39 – Prescription Drugs

HIP Plus and HIP Basic	Prior Authorization and Exclusions
The prescription drug benefit will cover at least one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. The *HIP Plus* formulary is not limited to only generic prescription drugs The *HIP Basic* benefit will have a generic drug formulary. All other benefits are the same as *HIP Plus*. This benefit is provided through the MCEs, and the exact drugs covered under the formulary may vary by MCE. **Duration/Scope Limit**: Limit on days supply, limit on number of prescriptions, limit on brand drugs, other coverage limits, Preferred Drug List	MCEs may establish PA requirements, such as: • General member information • A justification of need for Rx related to the medical needs of the member • A planned course of treatment, if applicable, as related to the number of prescription drugs provided and duration of treatment PA requirements for prescription drugs may vary by MCE. MCEs will be required to have a process in place to allow drugs that are medically necessary but not included on the formulary to be accessed by members.

Table 40 – Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Therapy

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Rehabilitative and habilitative services are offered at parity and share the same or comparable benefit limits. **Duration/Scope Limit:** • *HIP Basic*: As an outpatient benefit, coverage is limited to 60 combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation. • *HIP Plus*: As an outpatient benefit, coverage is limited to 75 combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation.	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment *HIP Basic* coverage does **not** include nonsurgical treatment of TMJ. (Treatment of TMJ is a covered service for *HIP Plus*.)

Table 41 – Durable Medical Equipment (DME)

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit includes but is not limited to: • Wheelchairs • Crutches • Respirators • Traction equipment • Hospital beds • Monitoring devices • Oxygen-breathing apparatus • Insulin pumps Training for use of DME and applicable rental fees are also covered. Covered services are only for the basic type of DME necessary to provide for medical needs and do not include nondurable supplies that are not an integral part of the DME setup. **Duration/Scope Limit**: 15-month rental cap/ one every 5 years per member - replacement	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment DME does **not** include • Corrective shoes • Arch supports • Dental prostheses • Deluxe equipment • Common first-aid supplies • Nondurable supplies Other noncovered services include but are not limited to equipment not suitable for home use.

Table 42 – Prosthetics

HIP Plus and HIP Basic	Prior Authorization and Exclusions
A prosthetic device means an artificial arm or leg or any portion thereof. Orthotic devices are also covered under this benefit as custom-fabricated braces or supports designed as a component of an artificial arm or leg. Covered services include the purchase, replacement, or adjustment of artificial limbs when required due to a change in physical condition or body side due to abnormal growth. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 43 – Corrective Appliances

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit includes but is not limited to: • Hemodialysis equipment • Breast prostheses • Back braces • Artificial eyes • One pair eyeglasses due to cataract surgery • Ostomy supplies • Prosthetics (all prosthetics except prosthetic limbs) Appliance must be medically necessary and used to restore function or to replace body parts. Coverage is not intended for nondurable appliances. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Items **not** included by the benefit include but are not limited to: • Artificial or prosthetic limbs • Cochlear implants • Dental appliances • Dentures • Foot orthotics • Corrective shoes • Arch supports for plantar fasciitis, flat feet, fallen arches, or corns

Table 44 – Cardiac Rehabilitation

HIP Plus and HIP Basic	Prior Authorization and Exclusions
As an outpatient benefit, coverage is limited as combined visits annually for physical therapy, occupational therapy, speech therapy, and pulmonary rehabilitation. The inpatient benefit is also referenced in the *Table 31 – Cardiac Rehabilitation – Inpatient*. Benefit includes services for the improvement of cardiac disease or dysfunction. Rehabilitative services are offered at parity and share the same or comparable benefit limits. **Duration/Scope Limit:** • *HIP Basic*: As an outpatient benefit, coverage is limited to 60 combined visits annually for physical therapy, occupational therapy, speech therapy, and pulmonary rehabilitation. • *HIP Plus*: As an outpatient benefit, coverage is limited to 75 combined visits annually for physical therapy, occupational therapy, speech therapy, and pulmonary rehabilitation.	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 45 – Medical Supplies

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit includes casts, dressings, splints, and other devices used for reduction of fractures and dislocations. **Duration/Scope Limit**: None	Benefit does **not** include nondurable supplies and/or convenience items.

Table 46 – Pulmonary Rehabilitation

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit consists of services that are for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent emergency room visits, progressive dyspnea, hypoxemia, or hypercapnia. Rehabilitative services are offered at parity and share the same or comparable benefit limits. **Duration/Scope Limit**: • *HIP Basic*: As an outpatient benefit, coverage is limited to 60 combined visits annually for physical therapy, occupational therapy, speech therapy, and cardiac rehabilitation. • *HIP Plus*: As an outpatient benefit, coverage is limited to 75 combined visits annually for physical therapy, occupational therapy, speech therapy, and cardiac rehabilitation.	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 47 – Skilled Nursing Facility (SNF)

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Covered services include: • Semiprivate room (private room provided when medically necessary) • Drugs • Specialty pharmaceuticals • Medical social services • Short-term physical, speech, occupational therapies (subject to limits) • Other services generally provided **Duration/Scope Limit**: 100 days per benefit period	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment An SNF does not include any institution or portion of any institution that is primarily for rest, the aged, nonskilled care, or care of mental diseases or substance abuse. Room-and-board services are not covered when temporary leave permitted.

Table 48 – Autism Spectrum Disorder Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit was formerly known as Pervasive Development Disorder (PDD). Benefit provides coverage for Asperger syndrome and autism. Coverage is for services provided as prescribed by the treating physician in accordance with the treatment plan. **Duration/Scope Limit**: • *HIP Basic*: As an outpatient benefit, coverage is limited to 60 combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation. • *HIP Plus*: As an outpatient benefit, coverage is limited to 75 combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation.	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 49 – Hearing Aids

HIP Plus and HIP Basic	Prior Authorization and Exclusions
This benefit is provided via substitution from the State Plan. **Duration/Scope Limit**: One hearing aid per member every 5 years.	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 50 – Home Health – Medical Supplies, Equipment, and Appliances

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefits include medical supplies in connection with home health care. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 51 – Laboratory – Freestanding and Hospital-Based

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Coverage includes laboratory benefits provided as outpatient services when medically necessary. Benefit includes lab tests, x-rays, imaging (MRI, CT, PET), pathology, radiology, EKG, and EEG. Coverage also includes magnetic resonance angiography (MRA) and single-photon emission computed tomography (SPECT) scan. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Coverage does **not** include x-ray or lab expenses related to physical exams when provided for employment, school, sports programs, travel, immigration, or administrative or insurance purposes.

Table 52 – Preventative Care Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Physician services for wellness and preventive services include but are not limited to routine physical exam, routine total blood cholesterol screening, routine gynecological services, and routine immunizations. The following are included: • All preventive items or services that have a rating of "A" or "B" by the U. S. Preventive Services Task Force (USPSTF) • Immunizations recommended for the individual's age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) • For infants, children, adolescents, and adults, preventive care and screenings included in the Health Resources and Services Administration (HRSA) Bright Futures comprehensive guidelines • Preventive screenings for women as recommended by the Institute of Medicine (IOM) **Duration/Scope Limit**: None	None

Table 53 – Routine Prostate Specific Antigen (PSA) Test

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit includes routine prostate specific antigen (PSA) test. **Duration/Scope Limi**t: One test annually for an individual who is at least 50 years old, or less than 50 years old if at high risk for prostate cancer.	None

Table 54 – Diabetes Self-Management Training

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Coverage includes diabetes self-management training services. **Duration/Scope Limit**: Limited to physician-authorized visits: • After receiving a diagnosis of diabetes • After receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management • For re-education or refresher training	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 55 – Health Education

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Benefit includes classes in nutrition or smoking cessation when referred by the member's physician. **Duration/Scope Limit**: Three visits	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 56 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Services provided under EPSDT may include preventive and diagnostic services that are medically necessary and may need continued treatment. **Duration/Scope Limit**: EPSDT is required for 19 and 20 year olds.	None

Table 57 – Chiropractic Services (Pregnancy Benefit)

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Chiropractic coverage is only offered to women who become pregnant while enrolled in *HIP Plus* or *HIP Basic* and thus receive State Plan equivalent benefits. Coverage is limited to services related to pregnancy, conditions that may complicate the pregnancy, or urgent care services. **Duration/Scope Limit**: Limited to five visits and 50 therapeutic physical medicine treatments per member per year.	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 58 – Nonemergency Transportation Services (Pregnancy Benefit)

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Nonemergency transportation coverage is only offered to women who become pregnant while enrolled in *HIP Plus* or *HIP Basic* and thus receive State Plan equivalent benefits. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment Coverage is provided subject to program restrictions.

Table 59 – Medicaid Rehabilitation Option (MRO) (Pregnancy Benefit)

HIP Plus and HIP Basic	Prior Authorization and Exclusions
MRO coverage is only offered to women who become pregnant while enrolled in *HIP Plus* or *HIP Basic* and thus receive State Plan equivalent benefits. MRO services are designed to assist in the rehabilitation of the consumer's optimum functional ability in daily living activities. Providers assess the consumer's needs and strengths and determine how MRO services can assist in reaching the consumer's rehabilitative and recovery goals. **Duration/Scope Limit**: None	Currently, no PA requirements and no benefit limitations are imposed for members receiving MRO services during the benefit period.

Table 60 – Health Education – Smoking Cessation (Pregnancy Benefit)

HIP Plus and HIP Basic	Prior Authorization and Exclusions
Smoking cessation coverage is only offered to women who become pregnant while enrolled in *HIP Plus* or *HIP Basic* and includes State Plan equivalent benefits. The benefit includes up to 12 weeks in a smoking cessation course providing treatment and counseling. **Duration/Scope Limit**: 12-week course	MCEs may establish PA requirements, such as: • General member information • A justification of services rendered for the medical needs of the member • Planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Table 61 – Dental (*HIP Plus* and Pregnancy Benefit)

HIP Plus and HIP Basic	Prior Authorization and Exclusions
For *HIP Plus*, dental benefits include: • Evaluations and cleanings (two per person per benefit year) • Bitewing x-rays (four x-rays per person per benefit year) • Comprehensive x-rays (one complete set every 5 years) • Minor restorative services, such as fillings (four per person per benefit year • Major restorative services, such as crowns (one per person per benefit year) For *HIP Basic*, dental benefits are offered only as a pregnancy benefit. Otherwise, dental benefits are not included in *HIP Basic*. Pregnancy dental benefits are equal to *HIP Plus* and State Plan benefits. **Duration/Scope Limit**: See above	The dental insurer may establish PA requirements, such as general member information and a justification for the type of dental services rendered based on the medical needs of the member.

Table 62 – Vision (*HIP Plus* and Pregnancy Benefit)

HIP Plus and HIP Basic	Prior Authorization and Exclusions
For *HIP Plus*, vision benefits include: • Routine exam (one every 2 years) • Eyeglasses, including frames and lenses (one pair every 5 years if there is not a sufficient change in prescription [vision], loss, irreparable damage, or theft) – Frames include but are not limited to plastic or metal. – Not all frames and lenses are covered, unless medically necessary. Members may choose to upgrade frames and lenses and pay the difference. • Replacement eyeglasses (covered when medical necessity guidelines met or due to loss, theft, or damage beyond repair) • Contact lenses (covered for medical necessity, such as facial deformity or allergy to frame prevents wearing eyeglasses) • Vision surgeries (covered for medical necessity) • Vision training therapies (covered for medical necessity) For *HIP Basic*, vision services are offered only as a pregnancy benefit. Otherwise, vision services are not included in *HIP Basic*. Pregnancy vision benefits are equal to *HIP Plus* and State Plan benefits. **Duration/Scope Limit**: See above	The vision insurer may establish PA requirements, such as general member information and a justification for the type of vision services rendered based on the medical needs of the member or the dollar amount of the service.

Table 63 – Bariatric Surgery (*HIP Plus* Benefit)

HIP Plus Only	Prior Authorization and Exclusions
To be eligible for bariatric surgery benefits, the *HIP Plus* member must meet the one of the following criteria: • Have morbid obesity that has persisted for at least 5 years' duration, and physician-supervised nonsurgical medical treatment has been unsuccessful for at least 6 consecutive months • Successfully achieved weight loss after participating in physician-supervised nonsurgical medical treatment but has been unsuccessful at maintaining weight loss for 2 years (> 3 kg [6.6 lb.] weight gain) Bariatric surgery is not a covered benefit in *HIP Basic*. **Duration/Scope Limit**: None	MCEs may establish PA requirements, such as: • General member information • Physician documentation • Documentation of attempt to follow nonsurgical treatment and duration prior to surgery • Documentation of pre- and post-operative expectations • Behavioral health evaluation • Consultation reports from other specialists • A justification of services rendered for the medical needs and circumstances of the member Benefit does **not** include personal comfort items (including those services and supplies not directly related to care, such as guest meals and accommodations or personal hygiene products), or room and board when temporary leave permitted.

HIP State Plan – Plus and Basic

Members on *State Plan – Plus* or *State Plan – Basic* will receive Indiana State Plan level benefits, including MRO, nonemergency transportation, and chiropractic care. The full list of services is available on the Indiana Medicaid member website at indianamedicaid.com (see Package A information on the *What Is Covered by Indiana Medicaid* page). The cost-sharing requirements for these members mirror those of the *HIP Plus* or *HIP Basic* program.

Presumptive Eligibility Adult

Services rendered under *PE Adult* are reimbursed under the managed care delivery system by the MCE with which the member is enrolled. During the presumptive eligibility period, providers must submit *PE Adult* claims to the appropriate MCE using the member's PE identification number. The *Adult PE* benefit plan mirrors the *HIP Basic* benefit. Individuals who receive *PE Adult* will have copayments that mirror the amounts that must be paid when enrolled in *HIP Basic*. A copayment will be applied for each service that the *PE Adult* member receives.

Managed Care Entities

All HIP 2.0 beneficiaries are enrolled to receive service through an MCE under contract to the State. The MCEs are subject to the federal laws and regulations as specified in *Code of Federal Regulations 42 CFR Part 438*. The HIP 2.0 beneficiary will be given an opportunity to select an MCE at the time of application. A HIP 2.0 beneficiary who does not make an MCE selection at the time of application may be auto-assigned to a HIP 2.0 MCE by the State. Except in cases of presumptive eligibility, auto-assignment may occur after the date on which the State made the eligibility determination.

The State may adjust the auto-assignment methodology. The State may consider assignment to the lowest-cost MCE, or to the MCEs that demonstrate higher quality scores or better health outcomes, or to MCEs on a rotating basis. Any change to the auto-assignment methodology must be approved by the CMS before implementation. Beneficiaries will be advised both at the time of application, and upon receiving an initial invoice, of the auto-assignment and their right to change MCEs prior to making their first POWER Account contribution. The notice to beneficiaries will include information on the process to change MCEs.

The State contracts with an enrollment broker, MAXIMUS, to assist interested applicants with their MCE selection so they can make an informed decision. The enrollment broker will provide the applicant with appropriate counseling on the full spectrum of available MCE choices and will address any questions the applicant may have. After an MCE has been selected and the beneficiary has made either their Fast Track prepayment or first POWER Account contribution, or has begun coverage in *HIP Basic* after nonpayment, the beneficiary is required to remain with that MCE for 12 months.

POWER Account Cards for Members

Within 5 calendar days of a new member's full enrollment, the MCE will send the new member a Welcome Packet. The Welcome Packet will include a new member letter, explanation of where to find information about the MCE's provider network, a copy of the member handbook, and the member's ID card.

For HIP members, the Welcome Packet must also include a POWER Account debit card.* For POWER Account debit cards, the MCE may choose to send the debit card separately from the Welcome Packet; provided, however, that the Welcome Packet includes information informing the member that the POWER Account debit card will be mailed at a later date. The same card may serve as both the member ID card and POWER Account debit card. For HIP, the member ID card must include the member's RID, as well as the applicability of cost sharing. Specifically, at minimum, the card must indicate emergency services copayments and other copayments that may apply, and direct the provider to call the MCE for specific amounts.

> **Note:* *Effective February 1, 2017, the IHCP discontinued use of the POWER Account debit cards within the HIP program. HIP members are no longer issued debit cards, and MCEs no longer support the debit card infrastructure for members who already have debit cards.*

For HIP members, the Welcome Packet must also include educational materials about unique features of the program, including but not limited to the following:

- POWER Account
- Member required cost sharing
- Nonpayment penalties
- POWER Account rollover, including the recommended preventive care services for the member's benefit year
- If applicable, general information regarding the importance of timely completion of the comprehensive health assessment for members initially identified on the application as potentially medically frail

Figure 1 – Sample Anthem HIP Member Card with Dental and Vision

Figure 2 – Sample Anthem HIP Basic

Figure 3 – Sample Anthem *HIP Maternity* Card

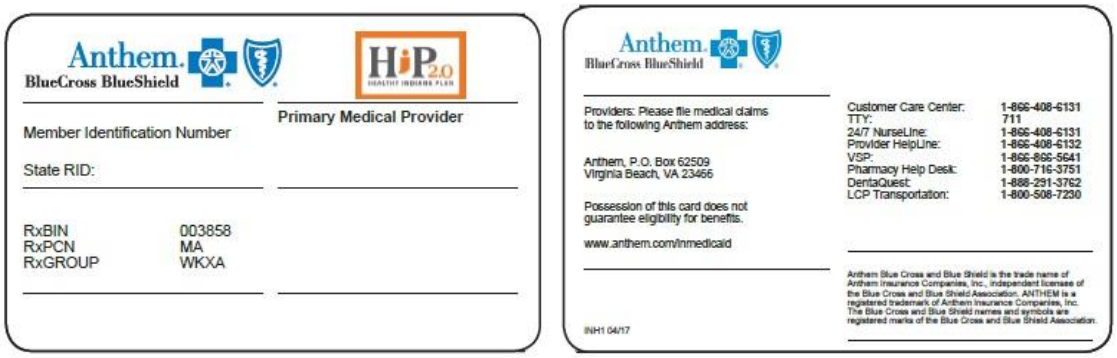

Figure 4 – Sample MDwise HIP Member Card

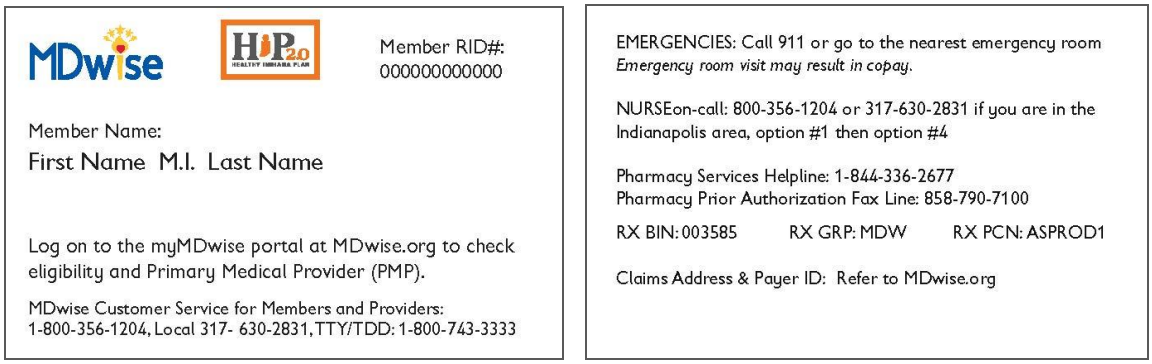

Figure 5 – Sample MHS HIP Member Card

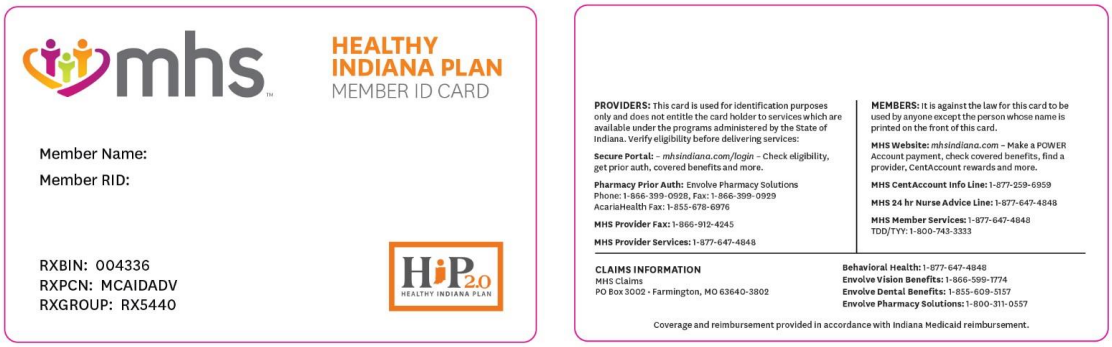

Figure 6 – Sample CareSource HIP Member Card

Note: CareSource was added as an MCE for HIP effective January 1, 2017.

Carved-In Services

Pharmacy services, as well as vision and dental services, when applicable, are carved into the HIP managed care arrangement.

Dental Services

Dental services are provided only to *HIP Plus* members who are making monthly contributions to their POWER Account, members who are enrolled in the *HIP State Plan* (*Plus* or *Basic*), and HIP members eligible for pregnancy benefits. Dental benefits are provided by the MCE and may be subcontracted to a dental benefit manager (DBM). See the MCE website for the appropriate DBM.

Vision Services

Vision services are provided only to *HIP Plus* members who are making monthly contributions to their POWER Account, members who are enrolled in the *HIP State Plan* (*Plus* or *Basic*), and HIP members eligible for pregnancy benefits. Vision benefits are provided by the MCE and may be subcontracted to a vision services provider. See MCE website for the appropriate information.

Pharmacy Services

Pharmacy benefits are provided by the MCE and may be subcontracted to a pharmacy benefits manager (PBM). The MCEs are responsible for managing this vendor and coordinating the benefits. Each MCE has its own contract with the PBM of their choice. Select pharmacy services may be carved out (see the *Carved-Out Services* section).

Table 64 – Pharmacy Services

Anthem	MHS	MDwise	CareSource*
Pharmacy Information 1-866-398-1922 1-844-520-2680 (Express Scripts) Fax: 1-855-875-3627	HIP Pharmacy Link 1-855-772-7125 (US Script) Fax: 1-866-399-0929 (standard) Fax: 1-855-678-6976 (specialty)	Pharmacy Resources 1-844-336-2677 Fax: 1-858-790-7100	CareSource Indiana 1-844-607-2831 Fax: 1-844-432-8924

**Note: Effective January 1, 2017, CareSource was added as a health plan option for HIP members.*

Carved-Out Services

Certain services are carved out of the HIP managed care program, meaning that they are the financial responsibility of the State. For carved-out services, providers should follow fee-for-service (FFS) procedures for PA and billing.

Medicaid Rehabilitation Services (MRO)

The IHCP covers MRO services provided to HIP members receiving *HIP State Plan – Plus* or *HIP State Plan – Basic* benefits. These services are carved out of managed care and reimbursed to community mental health centers (CMHCs) under the FFS delivery system. MCEs are not responsible for claim reimbursement for such services. However, the MCEs are responsible for ensuring care coordination with physical and other behavioral health services for individuals receiving MRO services. The MCE must provide all medically necessary community-based, partial hospital, and inpatient hospital behavioral health services.

The services provided by the CMHCs are to be reimbursed at no less than the Medicare rate or 130% of Medicaid FFS for any covered non-MRO service that the CMHC provides to a HIP member. *HIP State Plan – Basic* member copayment obligations are deducted automatically during claim adjudication; CMHCs are reminded to collect copayments at the time of service.

Hepatitis C

Effective September 1, 2016, all covered hepatitis C drugs will be reimbursed through the FFS pharmacy benefit manager (PBM), including those dispensed to members enrolled in HIP. All HIP hepatitis C drug claims will be processed by the FFS PBM for dates of service on or after September 1, 2016. Providers should refer to the Indiana Medicaid Preferred Drug List (PDL) for information regarding preferred status and PA requirements for hepatitis C agents. The FFS PDL and PA criteria can be accessed from the Pharmacy Services quick link at indianamedicaid.com.

Nursing Facility Placement

Any admission or discharge of an IHCP member enrolled in HIP must be reported to both the Division of Aging (DA) and the Division of Family Resources (DFR) within 10 days of the event. Providers should report the event to the DA through the Path Tracker tool. Reports should be made to the DFR via the online Benefits Portal, by fax or mail, or by calling 1-800-403-0864.

Extended Nursing Facility Stays

Providers should understand that reporting admission of a HIP member to the nursing facility will not automatically change the coverage category and benefit plan for the member. A HIP member can be admitted to a nursing facility and remain enrolled in the HIP program; however, coverage of skilled nursing care for most HIP members is limited to 100 days.

Stays beyond this limit will require the member's enrollment to be transitioned from HIP to an FFS coverage category and benefit plan to continue Medicaid coverage. To transition, HIP members must qualify under the income and resource limits associated with FFS benefits. Specific steps must be taken by the nursing facility to facilitate the member's transition:

All nursing facility stays for HIP members require PA. If a member's stay is expected to extend beyond the original PA time frame, the provider should request an extension of the PA from the enrolling MCE before the original PA expires to allow time for assessment and possible transition to FFS coverage.

The nursing facility must complete the Preadmission Screening and Resident Review (PASRR) process and report the member's level of care (LOC) to the DA using the Path Tracker tool. If appropriate, the nursing facility must notify the enrolling MCE of the intent to extend a member's stay and the need to transition the member to FFS coverage.

The nursing facility must notify DFR of the need to move the member to FFS coverage. Notice should be made via the online Benefits Portal, by fax or mail, or by calling 1-800-403-0864. The following information must be provided:

- Member's full name
- Medicaid Member ID (also known as RID)
- Social Security number
- Date of birth
- Admission date
- Name and address of the nursing facility

The nursing facility is expected to complete the transition steps within the first 60 days of a HIP member's admission. After 60 calendar days, if the member remains in the facility, a member's assessment and LOC determination has not been initiated, and the member continues to be enrolled with the MCE, the nursing facility may be liable for any costs associated with the member's long-term stay. The time limit is established to ensure the appropriate reimbursement (managed care versus FFS) for services rendered without interrupting the care being delivered to the member.

Billing for Extended Nursing Facility Stays for HIP Members

When a HIP member in a nursing facility is transitioning from HIP to FFS, it is the nursing facility's responsibility to meet the assessment and notification obligations in a timely manner. When completing this process, nursing facilities are reminded that coverage category changes are prospective; therefore, changes are effective on the first of the month following the date the request is made. Nursing facilities must work with the MCE on the submission of PA requests and claims for the dates of service during the transition period. If the facility has met the required notice and assessment obligations but a request for PA or a claim is denied by the MCE, the provider must exhaust all grievances and appeals processes with the MCE to resolve the issue.

If the nursing facility cannot resolve the issue with the MCE, the facility may request a retroactive transition date for the member's disenrollment from managed care and enrollment in FFS from DFR. Requests must include the following:

- A provider-generated claim (or copy of same) that clearly shows that the claim was denied by the enrolling MCE
- Verification that all grievances with the MCE have been exhausted
- An explanation of the situation

All requests will be reviewed on a case-by-case basis; approval of a retroactive transition date is not guaranteed.

Note:	*These requests should not be made to the Office of Medicaid Policy and Planning (OMPP) or to the IHCP provider representative.*

Questions about IHCP managed care member services should be directed to the MCE with which the member is enrolled.

Reimbursement

The reimbursement rate is the amount of reimbursement MCEs pay to providers participating in HIP. This amount is established by the FSSA secretary and is based on a Medicaid reimbursement formula which is comparable to one of the following:

- The federal Medicare reimbursement rate for the service provided
- One hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate

Hospital Assessment Fee

HIP is funded in part through Indiana's existing cigarette tax revenues that support the current HIP program, as well as funds from the Hospital Assessment Fee (HAF). The HAF is an existing program that was authorized by the Indiana General Assembly in 2011, reauthorized in 2013 and codified in statute at *IC 16-21-10* through 2017. The HAF is assessed against all licensed acute hospitals and private psychiatric hospitals, and was designed to increase hospital inpatient and outpatient reimbursement to align with the level of payment that would be paid under the federal Medicare program. The State also maintains a share of the HAF assessment to cover costs related to the Medicaid program.

The IHCP modified the HAF payment distributions to include increased reimbursement to eligible hospitals for services provided to all HIP members, including *PE Adult* HIP members, in January of 2016. HIP MCEs apply HAF adjustment factors accordingly when adjudicating claims. Non-HAF-eligible hospitals will continue to be reimbursed applying current rates and methodologies.

Inpatient Hospital Services

Effective February 1, 2016, HAF-eligible hospitals will be reimbursed for inpatient hospital services rendered to all HIP members using the Medicaid All-Patient Refined Diagnosis-Related Group (AP-DRG) or LOC methodology, as appropriate, with the HAF adjustment factors applied. Indiana Medicaid Medical Education payments are not impacted by this change and will continue to be paid separately. This change will apply retroactively to dates of service on or after January 1, 2016.

The HAF adjustment factor will apply to inpatient claims with "from" dates of service on or after January 1, 2016. Inpatient admissions that occur before that date will not be processed under the new methodology even if the discharge date is on or after January 1, 2016. See the *Hospital Assessment Fee* module for more information.

Outpatient Hospital Services

HAF-eligible hospitals are reimbursed for outpatient hospital services rendered to HIP members as follows:

- HIP expansion population: Reimbursement is based on Medicare rates.
- HIP low-income parent and caretaker population: Reimbursement is based on 130% of Medicaid rates.

A separate payment is made to account for the difference between the initial base reimbursement and the enhanced HAF-adjusted amount. Effective March 1, 2016, HAF-eligible hospitals will be reimbursed for outpatient hospital services rendered to all HIP members using the Medicaid rate methodology with the HAF adjustment factors applied directly to the claim payment. For the HAF adjustment factor for outpatient rates, see the *Hospital Assessment Fee* module. Reimbursement for outpatient laboratory services, defined as the procedure codes listed on the Medicare Clinical Laboratory Fee Schedule, are not subject to the HAF increase due to federal payment limitations. The HAF adjustment factor will apply to outpatient hospital claim detail lines for dates of service on or after March 1, 2016.